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Health Care Lawyer

The newsletter of the Illinois State Bar Association's Section on Health Care Law

All the latest developments in health care law

BY W. EUGENE BASANTA AND CHELBIE A. MITCHELL

Cases

Federal decisions

Supreme Court rules that ERISA preempts state reporting law

Under Vermont law, all health care plans are required to file claims data reports and other information with a state agency. The state statute specifically applies to health plans established by employers and regulated by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U. S. C. §1001 et seq. In this case, the state agency issued a subpoena to the third party administrator (TPA) of the respondent-company's nationwide self-insured employee health benefit plan to produce claims data for Vermont employees in the respondent's plan. Concerned about

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MEDICARE: Claim review programs could be improved with additional prepayment reviews and better data

[**Editor's Note:** The regulatory environment surrounding Medicare reimbursement for hospitals and physicians is incredibly complex. As a result, a significant feature of any hospital compliance program focuses on proper billing and coding for services and procedures paid for by this program. Given the amount of money spent by the federal government for hospital services under Medicare and the complexity of these payment systems, the federal government has initiated a variety of audit programs to insure that providers code and bill properly. The most notable of these

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All the latest developments in health care law

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employee privacy, the respondent told the TPA not to provide the requested data. The respondent then filed suit against the state on the theory that the ERISA preempted application of the state data collection law to its plan. The district court ruled in favor of the state, while the Second Circuit Court of Appeals found that ERISA preempted Vermont's law. The United States Supreme Court, in a 6-2 decision, affirmed the appellate court's ruling.

First, the Court looked to ERISA's express language preempting, "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. §1144(a). As Justice Kennedy explained, under this provision, ERISA preempts any state law that has a "reference to" or an "impermissible connection with" ERISA plans. Justice Kennedy further noted that in order to evaluate whether an "impermissible connection" exists, the Court looks to ERISA's objectives "as a guide to the scope of the state law that Congress understood would survive," and at "the nature of the effect of the state law on ERISA plans." In examining the objectives of ERISA, the Court explained that "ERISA seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures" and that these "systems and procedures are intended to be uniform." ERISA preemption prevents multiple jurisdictions from creating and imposing their own regulations on benefit plans.

In the instant case, Vermont's statute and ERISA both contain mandated reporting, disclosure, and recordkeeping requirements for health benefit plans. As a result, in the majority's view, the Vermont statute must be preempted given that it necessarily "both intrudes upon 'a central matter of plan administration' and 'interferes with nationally uniform plan administration.'" The Court further held that, in examining the nature of the state law's effect, while the respondent was unable to show any economic costs, this was not necessary to call for preemption. In this regard, Justice Kennedy opined that "A plan need not wait to bring a pre-emption claim until confronted with numerous inconsistent obligations and encumbered with any ensuing costs."

Based upon this analysis, the Court affirmed the decision of the Second Circuit finding that ERISA preempted application of Vermont's law to ERISA governed plans. *Gobeille v. Liberty Mutual Insurance Co.,* No. 14-181 (U.S. Sup., Mar. 1, 2016).

Seventh Circuit rejects dentist's §1983 claim on the merits and as time-barred

The Seventh Circuit Court of Appeals recently rejected a dentist's claim under 42 U.S.C. §1983 that the defendants, individual employees of the Illinois Department of Financial and Professional Regulation (Department), violated his constitutional First Amendment rights by retaliating against him. The appeals court affirmed the district court's summary judgment for the defendants.

The instant case traces its history to 1988 when the plaintiff was under investigation by the Department for prescribing too much nitrous oxide to a child. Believing he was being unfairly treated at the time, the plaintiff contacted the Deputy Governor for assistance. A meeting with the Department was held after which the Department imposed lesser sanctions on the plaintiff. Thereafter, nothing else occurred between the plaintiff and the Department for 14 years.

In 2002, a second investigation began with a raid on plaintiff's office by the Department and DEA officials. The plaintiff believed this raid occurred because he had contacted the Deputy Governor in 1988. After two informal hearings in 2003 with Department officials regarding the plaintiff's prescription of drugs, the plaintiff refused the Department's offer to settle the matter with a six month suspension and mandatory continuing education. In 2004, a cease and desist order was entered against

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the plaintiff for the unlicensed practice of medicine based on the treatment of one of his patients with prescription pain medications. The plaintiff filed suit for judicial review of this order. Additionally, in 2004, the Department initiated proceedings to sanction the plaintiff for improperly prescribing controlled substances. In 2007, plaintiff contacted a state Senator regarding the cease and desist order, as well as other issues he had had with the Department. The Senator scheduled a meeting with the Deputy Director of the Department, which was ultimately cancelled due to weather.

In 2008, the Department Director vacated the 2004 cease and desist order. The circuit court then entered an agreed order declaring the 2004 cease and desist order null and void and dismissing the plaintiff's judicial review complaint with prejudice. In 2009, plaintiff filed suit in federal court against the Department for denying his Freedom of Information Act (FOIA) request concerning the complaint against him. This suit was later dismissed by stipulation in 2010.

In March of 2010 the plaintiff filed a §1983 claim in federal court against the defendants. The plaintiff asserted that the defendants' actions, including the cease and desist order, the administrative complaint, and their refusal to meet with him, were initiated in retaliation for his exercise of his First Amendment free speech rights, specifically his 1988 conversations with the Deputy Governor, his 2007 conversations with the state Senator, and his FOIA request.

The district court granted summary judgment for the defendants. While the trial court assumed that the plaintiff had engaged in protected activity and had suffered a deprivation, it nonetheless rejected his claim. In the court's view, the plaintiff failed to meet his *prima facie* burden due to a lack of evidence that any of the defendants had a retaliatory motive. The plaintiff appealed.

On appeal, the defendants first argued that the plaintiff's §1983 claim was barred by the two year statute of limitations. The appeals court agreed. To avoid the limitations period, the plaintiff analogized his claim to one for malicious prosecution and argued that his claim did not accrue until the proceedings conclude in his favor in 2008. The court rejected this analogy and further held that in any event, the plaintiff's claim was still time-barred because he argued that the defendants had retaliated against him for his 1988 conversation with the Deputy Governor and, as such, he did not have to wait for the order to be set aside before bringing his suit.

The defendants also claimed that the plaintiff's action failed on the merits. The appeals court explained that in order to establish a First Amendment retaliation claim, the plaintiff must show, that: "(1) he engaged in activity protected by the First Amendment, (2) he suffered an adverse action that would likely deter future First Amendment activity, and (3) the First Amendment activity was 'at least a motivating factor' in the defendants' decision to retaliate." In this case, the plaintiff presented no direct evidence to support his claim and relied instead on circumstantial evidence of a retaliatory motive. The court noted that, while the plaintiff argued that the defendants never explained why they took the actions against him, in fact, the Department explained in their administrative complaint that the cease and desist was for improperly prescribing a controlled substance to treat a medical condition. In addition, the court said, the plaintiff's evidence that the defendants' actions were retaliatory was "woefully insufficient to withstand summary judgment." Therefore, the appellate court affirmed the trial court's decision. *Gekas v. Vasiliades*, No. 814 F.3d 890 (7th Cir. 2016).

Illinois decisions

Tax exemption case to be heard by Illinois Supreme Court

The Illinois General Assembly set out to revise and clarify the statutory provisions governing the charitable tax exemption criteria for hospitals when it enacted Public Act 97-688. This legislation added 35 ILCS 200/15-86 to the Illinois Property Tax Code. In this section, the General Assembly sought "to establish a new category of ownership for charitable property tax exemption to be applied to not-for-profit hospitals and hospital affiliates" and to "establish quantifiable standards for the issuance of charitable exemptions for such property." §15/86(a)(5).

In January of 2016, the Fourth District Appellate Court found §15/86 to be facially unconstitutional because it did not expressly state, as provided in Article IX, section 6, of the Illinois Constitution that, to be exempt from taxation, property must be "used exclusively for. . . charitable purposes." *Carle Foundation v. Cunningham Township*, 45 N.E.3d 1173 (Ill. App. 4th Dist., 2016).

The Illinois Supreme Court has now agreed to review the appellate court's decision. *Carle Foundation v. Cunningham Township,* Nos. 120427 & 120433 (Ill. Sup., May 25, 2016).

Hospital prevails in medical staff reappointment dispute involving immunity

The Illinois courts are regularly asked to deal with disputes between hospitals and physicians involving medical staff privileges. As a result there is considerable jurisprudence looking at various issues that can arise in such litigation. A May decision from the Illinois Supreme Court looks at one aspect of this area, namely the interpretation of the immunity provisions set out in the Illinois Hospital Licensing Act (Licensing Act), 210 ILCS 85/10.2. This section states that hospitals and their committees, agents, and employees are immune from liability for civil damages in cases arising out of peer review and quality control activities, "except those involving wilful or wanton misconduct." The statute goes on to specify that, "[f]or the purposes of this Section, 'wilful and wanton misconduct' means a course of action that shows actual or deliberate intention to harm or that, if not intentional, shows an utter indifference to or conscious disregard for a person's own safety and the safety of others."

The case at hand involved the plaintiff, an obstetrician/gynecologist, who was licensed to practice in Illinois and had privileges at the defendant-hospital. In September of 2001, plaintiff was

reappointed to the defendant's medical staff, with his appointment automatically set to terminate at the end of May of 2002. In February of 2002, the plaintiff applied for reappointment to the staff. During the consideration of this application, questions arose as the appropriateness of several of the plaintiff's gynecological surgical cases. Following a lengthy peer review process, the defendant-hospital board decided in March, 2005 not to reappoint the plaintiff to the medical staff. During the three year pendency of the reappointment process, the plaintiff was technically still listed as on staff at the hospital.

In March, 2007 the plaintiff filed suit against the hospital, including a contract claim, seeking civil damages. The plaintiff asserted in his suit that the hospital had breached its contract with him by failing to follow its bylaws. The hospital moved for summary judgment arguing that it had followed its bylaws relating to the reappointment process and that, in any event, it was immune from civil damage liability under §10.2 of the Licensing Act, as well as under the federal Health Care Quality Improvement Act of 1986 (HCQIA) (42 U.S.C. §11101 et seq. The trial court agreed that the hospital was immune from damages under the Licensing Act and that it had complied with its bylaws and had not engaged in any willful and wanton conduct. The trial court further found that the plaintiff had failed to provide sufficient evidence to show that his non-reappointment was the product of improper competitive efforts by other physicians. The appellate court affirmed holding that, to apply the "wilfull and wanton" exception to immunity under §10.2, a plaintiff must allege some type of physical harm to a person's safety or the safety of others. *Valfer v. Evanston Northwestern Healthcare*, 31 N.E.3d, 883 (Ill. App. 1st Dist. 2015). The Illinois Supreme Court granted the plaintiff leave to appeal.

Most of the supreme court's analysis focused on the proper interpretation of the immunity provision's exception in §10.2. The plaintiff argued that the appellate court erred in construing §10.2 of the Licensing Act to mean that the "wilful and wanton" exception to immunity required him to plead and prove that physical harm resulted from the hospital's actions. The plaintiff asserted he had adequately shown "wilful and wanton misconduct" by alleging that the hospital did not follow its bylaws. The defendant-hospital responded that the appellate court had correctly determined that the plaintiff must show physical harm to establish wilful and wanton misconduct under the Licensing Act.

In the supreme court's view, the appellate court correctly interpreted the exception language.

> Reading section 10.2 as a whole, we find that the appellate court was correct in determining that the "wilful and wanton" exception is limited to physical harm. We agree that the only reasonable way to interpret the last sentence of the . . . section defining wilful and wanton misconduct is by finding that the phrase "utter indifference to or conscious disregard for a person's own safety and the safety of others" clarifies the kind of intentional "harm" the legislature had in mind. The last phrase of the exception's reference to safety clearly shows an intent that the harm contemplated is physical. Furthermore, if the legislature had intended to except from immunity any and all types of intentional harm, such as harm to one's reputation or economic well-being, it would surely negate the immunity entirely and would lead to an absurd result.

The court went on however to note that:

> Our decision today should not be interpreted as condoning sham peer review. Section 10.2 of the Licensing Act immunizes a hospital and those involved in its quality reviews from civil damages only, and then only if the review was undertaken based on the actual purpose specified by the statute—i.e., to maintain or improve the quality of health care.

The supreme court affirmed the appellate court's decision to upholding the trial court's order granting summary judgment in favor of the defendant-hospital. *Valfer v. Evanston Northwestern Healthcare*, No. 119220 (Ill. Sup., May 19, 2016).

Court upholds suspension of physician from Medicaid program

The plaintiff-physician, a rheumatologist licensed to practice in Illinois, appealed to the First District Appellate Court from a trial court ruling upholding the decision of the Illinois Department of Healthcare and Family Services (Department) to suspend him from the Medicaid program. The Department's administrative law judge (ALJ) had found that the plaintiff violated the Illinois Public Aid Code, 305 ILCS 5/12-4.25, by providing patient care of grossly inferior quality, putting patients at risk of harm, and exceeding patients' needs by prescribing excessive narcotic drugs. On appeal, the plaintiff argued that the Department's witness was not qualified to provide expert medical testimony and that the testimony was speculative; that the Department failed to demonstrate patient harm as required by the statute; and that the ALJ had made multiple factual errors.

As to the plaintiff's first argument, the appellate court noted that the expert was board- certified in internal medicine, while the plaintiff was a rheumatologist, a sub-specialty of internal medicine. However, the expert testified that he had training in rheumatology and treated patients with medical issues similar to the plaintiff's patients. Finding that the record showed that the expert "regularly treated rheumatologic patients," the court found that the expert's opinion was sufficient.

Next, plaintiff argued that because the expert had problems reading his patient records, which were incomplete, lacking information as to tests, preventive care, prescription details and so on, his opinion was "insufficient because it was based on guesses and speculation." The plaintiff also claimed that care could be properly provided without documentation. The court disagreed finding that the statute required physicians "to maintain and

retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance. . . ." 305 ILCS 5/5-5. Furthermore, the expert testified as to the types of information the plaintiff's charts were missing. From these records, the Department found that the plaintiff's care was of inferior quality, placed the patients at risk of harm, and was in excess of their needs. The appellate court upheld this decision.

The plaintiff next argued that the Department had improperly expanded the scope of §12-4.259A)(e)(2) of the Code. This statutory section allows for a provider to be sanctioned for furnishing care that is "harmful." In the instant case, the Department had found that the plaintiff had placed his patients "at a risk of harm." The plaintiff argued that this impermissibly lowered the standard of proof. However, because the plaintiff had failed to raise this argument at the administrative hearing, the appeals court said it was waived. Furthermore, the court noted that the Department had also found that the plaintiff had provided "grossly inferior treatment and. . . treatment in excess of patient needs" thus supporting the Department's actions in any case.

Lastly, the plaintiff contended that the ALJ's decision should be reversed due to multiple errors in her report. However, the appellate court found that none of the alleged errors warranted reversal of the Department's decision.

Having rejected the plaintiff's arguments, the appeals court upheld the decision of the trial court affirming the plaintiff's suspension from the Medicaid program for 12 months. *Khan v. Illinois Department of Healthcare and Family Services*, No. 1-14-3908 (Ill. App. 1st Dist., May 13, 2016).

Hospital prevails in apparent agency action brought by non-English speaking patient

In May, the First District Appellate Court affirmed the trial court's grant of summary judgment for the defendant-hospital in an action brought by the plaintiff-patient against the hospital on an apparent agency theory. The plaintiff in this case spoke Arabic, with only a limited verbal capacity in English. Furthermore, he could neither read nor write in either English or Arabic. Instead, he depended on his adult children, including his daughter, to read and translate documents for him.

In 2009 the plaintiff, with his daughter, visited his primary care physician's office. After an electrocardiogram (EKG), the physician concluded plaintiff was having a heart attack and told him he had to go to the hospital at once. An ambulance was called to the office and transported the plaintiff to the defendant-hospital. Later, the plaintiff's daughter and other relatives arrived at the defendant's emergency room. During his hospital stay, the plaintiff signed several forms in English including several consent to treatment forms each of which specifically stated that the physicians treating the plaintiff were independent contractors and not hospital employees or agents. The plaintiff could not read the forms he signed and relied on his daughter to read and explain each of them to him before signing. While hospitalized, the plaintiff contracted an infection and was discharged before the infection was cured. As a result, he had to be hospitalized at another hospital to treat the infection.

The plaintiff filed a medical malpractice action against the defendant-hospital claiming that the hospital and its physicians "had been negligent in failing to prevent, recognize, and treat his infection and had prematurely discharged him." He alleged that the physicians were the hospital's actual employees or agents, and alternatively that they were its "apparent" agents. The trial court granted summary judgment for the hospital and the plaintiff appealed on the issue of whether the physician specifically named by the plaintiff was the hospital's apparent agent.

The appeals court initially set out the elements of an apparent agency claim against a hospital. In order to present such a claim, a plaintiff must show that: "(1) the hospital, or its agent acted in a manner that would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital; (2) where the acts of the agent create the appearance of authority, the plaintiff must also prove that the hospital had knowledge of and acquiesced in them; and (3) the plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence." As the court went on to explain, "if a patient has actual or constructive knowledge that the doctor is an independent contractor, the hospital is not vicariously liable."

In the instant case the appellate court found that the plaintiff was unable to prove elements (1) and (2), or that the hospital held itself out. The named physician who treated the patient wore a lab coat with no reference to the hospital. In addition, the plaintiff signed several consent forms, each stating that the physicians and staff treating him were independent contractors and not employees or agents of the hospital. While the patient spoke only limited English and could not read it, his daughter, who was fluent in English, had read the forms and told her father to sign them. As a result, the appellate court held that the plaintiff was informed of the physician's independent contractor status. The court rejected the argument that the hospital was required to assure the plaintiff's actual or subjective understanding of the consent forms he signed. Therefore, the appellate court upheld the summary judgment in favor of the defendant-hospital. *Mizyed v. Palos Community Hosp.*, No. 1-14-2790 (Ill. App. 1st Dist., May 9, 2016).

Third District affirms approval of CON

In an April decision from the Third District Appellate Court involving application of the Illinois Health Facilities Planning Act (Planning Act), 20 ILCS 3960/1 et seq., which generated a vigorous criticism of the Planning Act by Justice Schmidt in his concurring opinion, as well as a pithy response by Justice Holdridge, the appeals court upheld the decision of the Illinois Health Facilities and Services Review Board (Board), granting a certificate of need (CON) to the defendant-hospital to build a new hospital in northern Illinois outside of Chicago. The case traces its history to December of 2009, when

the defendant-hospital filed its CON application. As noted by Justice Schmidt in his concurrence, the instant case is related to other proceedings that earlier generated a federal investigation of the Board.

After the hospital initially filed its application, the plaintiffs, including several other hospitals in the area, intervened in the administrative proceedings, challenging the defendant's application. Additionally, during the proceedings, one of the plaintiffs filed its own CON application to build a hospital in the area. This application was denied.

After an initial public hearing on the defendant's application, the Board staff prepared a State Agency Report (SAR) assessing whether the defendant's application met the review criteria set out in the relevant regulations. The SAR found the defendant in compliance with most review criteria, but found the proposal did not meet three criteria including:

> (1) planning area need, in that existing facilities in the relevant planning area were operating below capacity such that erecting a new facility would result in excess bed capacity in the area; (2) unnecessary duplication of service where existing facilities were not operating at full capacity; and (3) clinical services of other area providers would be adversely impacted, again due to a current underutilization of existing services.

Thereafter, in June, 2011, the Board voted to deny the application.

Upon notice of this decision, the defendant-hospital elected to place the matter before the Board again at a subsequent meeting. For this meeting, in response to the Board, the hospital provided additional information related to its application. Another SAR was prepared that again concluded the review criteria were not met and, in December of 2011, the Board again voted on the application. This second vote resulted in a tie, and therefore the application was denied.

In 2012 yet another public hearing was held regarding the application. At this third hearing, the defendant presented demographic data which, in opposition to the SAR, "actually projected significant population growth for the planning area and a corresponding increased need for a facility in accordance with the [defendant-hospital's] project." In a 6 to 3 vote the Board then approved the project.

The plaintiffs then filed suit for judicial review of the Board's decision in the circuit court. In November of 2013 the trial court upheld the Board's decision. The court found that the Board had provided adequate findings of fact and conclusions of law as a basis for its decision and that the record supported the decision. The plaintiffs appealed.

On appeal, the plaintiffs advanced several challenges to the Board's decision. These included, (1) that the Board failed to articulate with sufficient specificity its reasons for approving the defendant's CON application, (2) that the Board's decision was clearly erroneous, (3) that the Board's decision was both arbitrary and capricious in several aspects, and (4) that the Board's approval of the application deprived the plaintiffs of due process. Addressing each of these claims in turn, the appeals court rejected the plaintiffs' arguments. In doing so, the court noted that its role was not to determine if it agreed with the Board's decision, but rather whether there was competent evidence in the record to support that decision. Furthermore, the court noted that the Board was not precluded from approving an application simply because some of the review criteria were not met. "Under the Board's rules and governing case law, an application does not have to comply with all review criteria." Additionally the court was not persuaded that the Board's decision was arbitrary and capricious simply because it did not follow the staff's SAR or because its ultimate decision in favor of the application was contrary to its earlier decision to reject it.

Based on its analysis, the appellate court affirmed the decision of the trial court confirming the Board's decision. *Mercy Crystal Lake Hospital and Medical Center v. Illinois Health Facilities and Service Review Board*, Nos. 3-13-0947 & 3-13-0960 (Ill. App. 3d Dist., Apr. 22, 2016).

Relation back doctrine applied to a wrongful death claim based on malpractice

In a recent case, the First District Appellate Court was asked to resolve an issue of first impression for Illinois courts. Specifically, the court's task was to consider whether the medical malpractice statute of repose, 735 ILCS 5/13-2129a, precludes applying the relation back doctrine set out in 735 ILCS 5//2-616(b) in the context of a plaintiff's effort to add a claim under the Illinois Wrongful Death Act, 740 ILCS 180/0.01 et seq. The appellate court ruled that the relation back doctrine applied, allowing the plaintiff to add a wrongful death claim, even after the repose period.

In 2011, the patient, now deceased, brought a medical malpractice claim against multiple defendants, including institutional and individual health care providers, for misdiagnosing her macular pathology. The suit was filed within the two-year statute of limitation and the four-year statute of repose. In 2013, after the four-year statute of repose expired, the patient died. The court allowed the patient's daughter to amend the complaint and substitute herself as the plaintiff and as executor of the estate. In amending the complaint, the plaintiff-daughter added a wrongful death action. The trial court subsequently concluded the wrongful death claim was a new action barred by the four-year statute of repose and dismissed this claim. The court found no precedent to support application of the relation back doctrine in this situation. The plaintiff appealed.

On appeal, the plaintiff argued that "the relation back doctrine should apply because the original claims supplied defendants with the information necessary to prepare their defense to the amended claims." The negligent actions alleged in the amended complaint were, the plaintiff asserted, identical to those set out by the deceased in her original complaint. In response, the defendants argued that the relation back doctrine is not an exception to the medical malpractice statute of repose, that the more specific statute should govern over the

more general relation back statute, and that the statute of repose controlled because it is substantive and not procedural.

In its analysis, the appellate court first noted that the Wrongful Death Act creates a new cause of action, not recognized by the common law, allowing recovery for a decedent's survivors. The court referenced the text of the Act which states:

> Whenever the death of a person shall be caused by wrongful act, neglect, or default, and the act, neglect or default is such as would, if death had not ensued, have entitled the party injured to maintain an action and recover damages in respect thereof, then and in every such case the person who or company or corporation which would have been liable if death had not ensued, shall be liable to an action for damages, notwithstanding the death of the person injured, and although the death shall have been caused under such circumstances as amount in law to felony. 740 ILCS 180/1.

Additionally, the court also quoted Section 2 of the Act which provides that:

> Every such action shall be brought by and in the names of the personal representatives of such deceased person, and . . . the amount recovered in every such action shall be for the exclusive benefit of the surviving spouse and next of kin of such deceased person. In every such action the jury may give such damages as they shall deem a fair and just compensation . . . including damages for grief, sorrow, and mental suffering, to the surviving spouse and next of kin. . . . Every such action shall be commenced within 2 years after the death of such person . . . . 740 ILCS 180/2.

The appeals court then cited the Illinois Supreme Court's decision in *Wynes v. Armstrong World Industries, Inc*., 131 Ill. 2d 403, 546 N.E.2d 568 (1989) which held that, "[t]he 'injury' which opens the door to initiation of a personal injury suit . . . is not the same 'injury' which opens the door to a wrongful death suit" and that "[a] wrongful death action can only be instituted for the benefit of the next of kin who have suffered 'injury' because a family member had died when that family member's death result from an injury wrongfully caused by another. The precipitating 'injury' for the plaintiffs in a wrongful death action . . . is the death" The appeals court noted however that, "[a] wrongful death action will lie where the deceased had a claim that was not time-barred on or before his death."

Next, the appellate court looked to the statute establishing the limitation and repose periods for medical negligence claims.

> [N]o action for damages for injury or death against any physician, dentist, registered nurse or hospital . . . whether based upon tort, or breach of contract, or otherwise, arising out of patient care shall be brought more than 2 years after the date on which the claimant knew, or through the use of reasonable diligence should have known, or received notice in writing of the existence of the injury or death for which damages are sought in the action, whichever of such date occurs first, but in no event shall such action be brought more than 4 years after the date on which occurred the act or omission or occurrence alleged in such action to have been the cause of such injury or death. 735 ILCS 5/13-212(a) (West 2010).

The court in the instant case observed that, in *Hayes v. Mercy Hospital & Medical Center*, 136 Ill. 2d 450, 557 N.E.2d 873 (1990), an action involving a third party contribution claim, the Illinois Supreme Court concluded that "the medical malpractice statute of repose bars any action after the period of repose seeking damages against a physician or other enumerated health-care provider for injury or death arising out of patient care, whether at law or in equity" including the third party contribution claim. However, as the court here noted, the *Hayes* case did not involve the relation back doctrine.

Lastly, the court looked to the statute setting out relation back doctrine.

> The cause of action, cross claim or defense set up in any amended pleading shall not be barred by lapse of time under any statute or contract prescribing or limiting the time within which an action may be brought or right asserted, if the time prescribed or limited had not expired when the original pleading was filed, and if it shall appear from the original and amended pleadings that the cause of action asserted, or the defense or cross claim interposed in the amended pleading grew out of the same transaction or occurrence set up in the original pleading . . . and for the purpose of preserving the cause of action, cross claim or defense set up in the amended pleading, and for that purpose only, an amendment to any pleading shall be held to relate back to the date of filing of the original pleading so amended. 735 ILCS 5/2-616(b) (West 2010).

For guidance in applying this statute, the court referred to *Zeh v. Wheeler*, 111 Ill. 2d 266, 489 N.E.2d 1342 (1986). In *Zeh,* the court, stated that, "'[t]here is no reason to apply a statute of limitations when, as here, the respondent has had notice from the beginning that petitioner was trying to enforce a claim against it because of the events leading up to the death of the deceased in the respondent's yard.'" (quoting *Tiller v. Atlantic Coast Line R.R. Co.,* 323 U.S. 574, 581 (1945)).

With this background in mind, the court considered how to apply the relation back doctrine to the statute of repose. While the defendants cited multiple cases, the court rejected them because the

original complaint in each was not filed until after the four-year repose. Instead the court looked to *Sompolski v. Miller*, 239 Ill. App. 3d 1087, 608 N.E.2d 54 (1st Dist. 1992) where the representative of the deceased was able to use the relation back doctrine in a personal injury case after the two-year statute of limitations had run because the wrongful death claim made by the representative "arose from the same transaction or occurrence." Referencing *Zeh,* the *Sompolski* court stated that the relation back doctrine is appropriate so long as the defense has been apprised of the information needed to prepare a defense.

The appellate court, finding *Sompolski* analogous to the present case, reversed the trial court's ruling and remanded the case. *Lawler v. The University of Chicago Medical Center*, No. 1-14-3189 (Ill. App. 1st Dist., Mar. 25, 2016).

Court sustains revocation of physician's hospital privileges following rule of non-review

The plaintiff-physician sought a court order to enjoin enforcement of the decision of the defendant-nonprofit hospital's Board to revoke his medical staff membership and clinical privileges. The trial court found that the plaintiff's privileges had been revoked without proper notice and a hearing, and without any finding of imminent danger, in violation not only of the Illinois Hospital Licensing Act (Licensing Act), 210 ILCS 85/10.4, but also of the defendant's bylaws and credentials manual. The court entered a partial summary judgment for the plaintiff, permanently enjoining the defendant from enforcing the revocation. Additionally, the trial court ruled that the defendant was immune from civil damages under the Licensing Act, 210 ILCS 85/10.2 and the Health Care Quality Immunity Act of 1986 (HCQIA), 42 U.S.C. §11101 et seq. Therefore, the court entered a partial summary judgment for the defendant on the plaintiff's claim for damages. Both parties appealed.

On appeal, the court specifically noted that Illinois follows the "rule of non-review" of private hospital medical staff decisions. The court explained that under this rule, judicial review "is limited to whether the defendant's revocation decision was made in substantial compliance with its bylaws, and not whether the imposed discipline was appropriate." In this case, the appellate court held that the hospital-defendant had complied with section 10.4 of Illinois Hospital Licensing Act and the applicable provisions in its bylaws and credentials manual in revoking plaintiff's privileges. Further, the court upheld the lower court's finding regarding the defendant's damage immunity.

The plaintiff's difficulties in the instant case involved two arguments he had with members of the hospital's nursing staff. The arguments related to surgeries and included both yelling and physical contact by the plaintiff with a nurse. On one occasion a police report was filed. The defendant's credentials manual provided that if a practitioner engages in professional conduct within or outside the hospital, which is or is reasonably likely to be detrimental to the quality of patient care or disruptive to the hospital's operations disciplinary actions could be brought.

After the first incident, the defendant's Medical Executive Committee (MEC) scheduled a meeting and invited the plaintiff and the nurses to attend the meeting to discuss the incident. The plaintiff declined to attend the meeting for various reasons, including his attorney's advice. The second incident occurred the day before the scheduled meeting.

The MEC proceeded with its review meeting and recommended to the Board that the plaintiff undergo anger management counseling and make a formal apology. The plaintiff was informed of the MEC's recommendation. The next day, the Board met to review the incidents and decided to reject the MEC's recommendation and instead to revoke the plaintiff's hospital privileges. The plaintiff was notified of the Board's decision and its reasons, and that he had a right to request a hearing and appellate review. Additionally, the plaintiff was informed that the hospital would submit a report to the National Practitioner Data Bank as required by federal law.

In response, the plaintiff requested a hearing. A hearing committee was appointed at which the parties presented evidence and were allowed to questions witnesses. Following the hearing, the committee recommended that the Board's decision be affirmed. The plaintiff was informed of this recommendation and sought review by an appellate review committee. The plaintiff appeared and spoke during the hearing held by this committee. The review committee upheld the revocation recommendation. After further review by the Medical Staff/Board Liaison Committee, the hospital's Board reaffirmed the revocation of plaintiff's privileges.

The appellate court found that the hospital followed the proper steps in handling the plaintiff's disciplinary action.

> After reviewing the undisputed facts in the record, we find that the defendant's decision to revoke the plaintiff's staff membership and clinical privileges was made in compliance with section 10.4 of the Licensing Act and the applicable provisions in the Bylaws and Credentials Manual. The record shows that the plaintiff received proper notice of the Board's adverse action and his right to a hearing and appellate review. The record also shows that the plaintiff appeared with his attorney and fully participated in the hearing and the appellate review process.

From this perspective, the court held that the defendant was entitled to summary judgment on the plaintiff's claim for injunctive relief, and that the trial court had erred in entering a partial summary judgment and injunctive relief for the plaintiff. In addition, the court ruled that there was nothing in the record to suggest that the hospital had engaged in willful and wanton misconduct in revoking the plaintiff's privileges. As a result, the trial court's summary judgment for the defendant as to plaintiff's damage claim was proper. *Murfin v. St. Mary's Hospital*, No. 5-14-0136 (5th Dist., Mar. 8, 2016). ■

MEDICARE: Claim review programs could be improved

CONTINUED FROM PAGE 1

is the Centers for Medicare and Medicaid Services (CMS) Recovery Audit Program.

A recent Government Accountability Office (GAO) report, "Medicare: Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data," GAO-16-394 released May 13, 2016, looks at the current operations of Medicare audit contractors. A summary of this report is set out here. The full report is available at: http://www.gao.gov/assets/680/676526.pdf]

* * * *

Why GAO Did This Study

CMS uses several types of claim review contractors to help reduce improper payments and protect the integrity of the Medicare program. CMS pays its contractors differently—the agency is required by law to pay RAs [Recovery Auditors] contingency fees from recovered overpayments, while other contractors are paid based on cost. Questions have been raised about the focus of RA reviews because of the incentives associated with the contingency fees.

GAO was asked to examine the review activities of the different Medicare claim review contractors. This report examines (1) differences between prepayment and postpayment reviews and the extent to which contractors use them; (2) the extent to which the claim review contractors focus their reviews on different types of claims; and (3) CMS's cost per review and amount of improper payments identified by the claim review contractors per dollar paid by CMS. GAO reviewed CMS documents; analyzed CMS and contractor claim review and funding data for 2013 and 2014; interviewed CMS officials, claim review contractors, and health care provider organizations; and assessed CMS's oversight against federal internal control standards.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) uses different types of contractors to conduct prepayment and postpayment reviews of Medicare fee-for-service claims at high risk for improper payments. Medicare Administrative Contractors (MAC) conduct prepayment and postpayment reviews; Recovery Auditors (RA) generally conduct postpayment reviews; and the Supplemental Medical Review Contractor (SMRC) conducts postpayment reviews as part of studies directed by CMS. CMS, its contractors, and provider organizations identified few significant differences between conducting and responding to prepayment and postpayment reviews. Using prepayment reviews to deny improper claims and prevent overpayments is consistent with CMS's goal to pay claims correctly the first time and can better protect Medicare funds because not all overpayments can be collected. In 2013 and 2014, 98 percent of MAC claim reviews were prepayment, and 85 percent of RA claim reviews and 100 percent of SMRC reviews were postpayment. Because CMS is required by law to pay RAs contingency fees from recovered overpayments, the RAs can only conduct prepayment reviews under a demonstration. From 2012 through 2014, CMS conducted a demonstration in which the RAs conducted prepayment reviews and were paid contingency fees based on claim denial amounts. CMS officials considered the demonstration a success. However, CMS has not requested legislation that would allow for RA prepayment reviews by amending existing payment requirements and thus may be missing an opportunity to better protect Medicare funds.

The contractors focused their reviews on different types of claims. In 2013 and 2014, the RAs focused their reviews on inpatient claims, which represented about 30 percent of Medicare improper payments. In 2013 and 2014, inpatient claim reviews accounted for 78 and 47 percent, respectively, of all RA claim reviews. Inpatient claims had high average identified improper payment amounts, reflecting the costs of the services. The RAs' focus on inpatient claims was consistent with the financial incentives from their contingency fees, which are based on the amount of identified overpayments, but the focus was not consistent with CMS's expectations that RAs review all claim types. CMS has since taken steps to limit the RAs' focus on inpatient claims and broaden the types of claims being reviewed. The MACs focused their reviews on physician and durable medical equipment claims, the latter of which had the highest rate of improper payments. The focus of the SMRC's claim reviews varied.

In 2013 and 2014, the RAs had an average cost per review to CMS of $158 and identified $14 in improper payments per dollar paid by CMS to the RAs. The SMRC had an average cost per review of $256 and identified $7 in improper payments per dollar paid by CMS. GAO was unable to determine the cost per review and amount of improper payments identified by the MACs per dollar paid by CMS because of unreliable data on costs and claim review savings. Inconsistent with federal internal control standards, CMS has not provided written guidance on how the MACs should calculate savings from prepayment reviews. Without reliable savings data, CMS does not have the information it needs to evaluate the MACs' performance and cost effectiveness in preventing improper payments, and CMS cannot compare performance across contractors.

What GAO Recommends

GAO recommends that CMS (1) request legislation to allow the RAs to conduct prepayment claim reviews, and (2) provide written guidance on calculating savings from prepayment reviews. The Department of Health and Human Services disagreed with the first recommendation, but concurred with the second. GAO continues to believe the first recommendation is valid as discussed in the report. ■

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Wednesday, 07/13/16- Teleseminar— Income Tax Issues for Estate Planners, Part 2. Presented by the ISBA. 12-1 pm.

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Tuesday, 07/26/16- Teleseminar— Buying and Selling Distressed Real Estate, Part 1. Presented by the ISBA. 12-1 pm.

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Tuesday, 08/02/16- Teleseminar—Due Diligence in Real Estate Acquisitions. Presented by the ISBA. 12-1 pm.

Wednesday, 08/03/16- Teleseminar LIVE REPLAY—2016 UCC Update – Secured Transactions, Notes, Leases, Sales & More. Presented by the ISBA. 12-1 pm.

Thursday, 08/04/16- Webinar— Introduction to Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Monday, 08/08/16- Teleseminar LIVE REPLAY— Post-Closing Adjustments & Issues in Business Transactions. Presented by the ISBA. 12-1 pm.

Tuesday, 08/09/16- Teleseminar— Charging Orders in Business Transactions. Presented by the ISBA. 12-1 pm.

Wednesday, 08/10/16- Teleseminar— Role of Public Benefits in Estate Planning. Presented by the ISBA. 12-1 pm.

Thursday, 08/11/16- Webinar— Advanced Tips for Enhanced Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Tuesday, 08/16/16- Teleseminar—Real Estate Finance, Part 1. Presented by the ISBA. 12-1 pm.

Wednesday, 08/17/16- Teleseminar— Real Estate Finance, Part 2. Presented by the ISBA. 12-1 pm.

Tuesday, 08/23/16- Teleseminar— Drafting Employment Separation Agreements. Presented by the ISBA. 12-1 pm.

Wednesday, 08/24/16- Teleseminar— Sales of Family Businesses: An Interdisciplinary Approach, Part 1. Presented by the ISBA. 12-1 pm.

Thursday, 08/25/16- Teleseminar— Sales of Family Businesses: An Interdisciplinary Approach, Part 2. Presented by the ISBA. 12-1 pm.

Thursday, 08/25/16- Webinar— Introduction to Boolean (Keyword) Searches for Lawyers. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Wednesday, 08/31/16- Teleseminar— Lawyer Ethics and Disputes with Clients. Presented by the ISBA. 12-1 pm.

September

Thursday, 09/01/16- Webinar— Introduction to Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Thursday, 09/08/16- Webinar— Advanced Tips for Enhanced Legal Research on Fastcase. Presented by the Illinois State Bar Association –

Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Thursday, 09/08/16- Webcast—Monetizing Intellectual Property. Presented by IP. 12:30 p.m. – 2:15 p.m.

Wednesday, 09/14/16- Webcast—Hot Topic: Union Dues/Fair Share—Friedrichs v. California Teachers Association. Presented by Labor and Employment. 10:00 a.m. – 12:00 p.m.

Thursday, 09/15/16- CRO—Family Law Table Clinic Series (Series 1). Presented by Family Law. 8:30 am – 3:10 pm.

Friday, 09-16-06- CRO and Live Webcast—The Fear Factor: How Good Lawyers Get Into (and avoid) Bad Ethical Trouble. Master Series Presented by the ISBA—WILL NOT BE RECORDED OR ARCHIVED. 9:00 a.m. – 12:15 p.m.

Thursday, 09-22-16- Webcast—Family Law Changes and Mediation Practice. Presented by Women and the Law. 11:00 a.m. – 12:00 p.m.

Thursday, 09/22/16- CRO and Webcast—Recent Developments in E-Discovery in Litigation. Presented by Antitrust. 1:00- 5:15 pm.

Thursday, 09/22/16- Webinar— Introduction to Boolean (Keyword) Searches for Lawyers. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Monday, 09/26/16- Friday, 09/30/16—CRO—40 Hour Mediation/Arbitration Training Master Series. Presented by the ISBA. 8:30 am – 5:45 pm each day.

Friday, 09-30-16—DoubleTree Springfield—Solo and Small Firm Practice Institute Series. Title TBD. Presented by GP, SSF. ALL DAY.

October

Thursday, 10/06/16- Webinar—Introduction to Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Thursday, 10-06-16—Webcast—Nuts and Bolts of EEOC Practice. Presented by Labor and Employment. 11:00 a.m. – 12:30 p.m.

Monday, 10-10-16—CRO and Fairview Heights, Four Points Sheraton—What You Need to Know to Practice before the IWCC. Presented by Workers Compensation. 9:00 a.m. – 4:00 p.m.

Thursday, 10/13/16- Webinar— Advanced Tips for Enhanced Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Wednesday, 10-19-16- CRO and Live Webcast—From Legal Practice to What's Next: The Boomer-Lawyer's Guide to Smooth Career Transition. Presented by Senior Lawyers. 12:00 p.m. to 5:00 p.m.

Wednesday, 10-19-16—DoubleTree Bloomington—Real Estate Law Update 2016. Presented by Real Estate. 8:15 a.m. – 4:45 p.m.

Thursday, 10/20/16- Webinar—Introduction to Boolean (Keyword) Searches for Lawyers. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Friday, 10/21/16- Galena, Eagle Ridge Resort—Obtaining a Judgement and Collections Issues. Presented by: Commercial Banking, Collections, and Bankruptcy. 8:50 am - 4:30 pm.

Friday, 10-28-16—CRO—Solo and Small Firm Practice Institute Series. Title TBD. Presented by GP, SSF. ALL DAY.

November

Wednesday, 11-02-16—Linder Conference Center, Lombard—Real Estate Law Update 2016. Presented by Real Estate. 8:15 a.m. – 4:45 p.m.

Thursday, 11/03/16- Webinar— Introduction to Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm

Thursday, 11/10/16- Webinar— Advanced Tips for Enhanced Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm.

Friday, 11-11-16—CRO and live Webcast—Motion Practice from Pretrial through Post Trial. Presented by Civil Practice and Procedure. 8:50 a.m. - 4:00 p.m.

Thursday, 11/17/16- CRO—Family Law Table Clinic Series (Series 2). Presented by Family Law. 8:30 am – 3:10 pm.

Thursday, 11/17/16- Webinar— Introduction to Boolean (Keyword) Searches for Lawyers. Presented by the Illinois State Bar Association – Complimentary to ISBA Members Only. 12:00- 1:00 pm ■

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